First Health Services of Montana

To transmit information:
FAX: 1-800-639-8982
PHONE: 1-800-770-3084

Mail: 4300 Cox Road
Glen Allen, VA 23060

DIRECTIONS: Please complete this form in its entirety in order for it to be processed. Attach additional sheets if necessary.

_____ **Initial enrollment** _____ **Re-enrollment**

Please Type or Print:

PATIENT INFORMATION		
SSN:	**DOB:**	**Sex:**
Name: Last:	**First:**	**Middle:**
Mailing Address:		**City:**
County:	**State:**	**Zip:**
Telephone No:		
Custodial Agency:		
RESPONSIBLE PARTY INFORMATION		
Name: Last:	**First:**	**Middle:**
Mailing Address:		
City:	**State:**	**Zip:**
Telephone No:		
Relationship to client:		
PROVIDER INFORMATION		
Provider Name:	**Provider No:**	
Address:		
City:	**State:**	**Zip:**
Telephone No:	**Fax No:**	
CLINICAL INFORMATION		
SED: Yes ☐ **No** ☐	**SDMI: YES** ☐ **No** ☐	
You need ONLY address elements that substantiate SED or SDMI determination:		
PSYCHIATRIC HISTORY		
Chief Complaint/History of Present Illness:		

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Name: Last _____ First: _____
SSN: _____

Outpatient History: Yes ☐ No ☐ **Briefly Describe:**
History of Inpatient Treatment: Yes ☐ No ☐ **Briefly Describe:**
Current Chemical Use/Abuse/Dependency: Yes ☐ No ☐ **Briefly Describe:**
SOCIAL HISTORY
Family Relationship Problems: Yes ☐ No ☐ **Briefly Describe:**
Peer Relationship Problems: Yes ☐ No ☐ **Briefly Describe:**
Work/School Performance Problems: Yes ☐ No ☐

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Name: Last _____ First: _____
SSN: _____

Delinquent Behaviors Not Described in Chief Complaint: Yes ☐ No ☐

Risk Factors: **(check all that apply)**	**Past/Dates**	**Present/Dates**
Domestic Violence	☐ _____	☐ _____
Suicidal Ideation	☐ _____	☐ _____
Victim of Child Abuse	☐ _____	☐ _____
Victim of Sexual Abuse	☐ _____	☐ _____
Eating Disorder	☐ _____	☐ _____
Evidence of Psychosis	☐ _____	☐ _____
Threat to Others (homicidal ideation)	☐ _____	☐ _____

Current Primary DSM-IV Diagnosis	
Axis I :	**Axis II:**
Axis III : (specify)	**Axis IV: (specify)**
Axis V: (GAF)	

Current Educational Status:
Choose One

No Formal Education Activity
Adult Education Classes/GED
Attends college Part-time
Attends college Full-time
Other
Home District School
Home School
Private School
Special Education Services
School Based Day Treatment

Current Employment Status:
Choose One

No Vocational Activity
No Vocational Activity; seeking job
Involved in Day Treatment
Job Corps
Being evaluated by Voc Rehab Svcs
Employed in Volunteer Work
Transitional Employment Program
Supported Employment
Part-time Gainful Employment
Full-time Gainful Employment
Homemaker
Retired, age 55 or over
Other

Current Residential Arrangement:
Choose One

Homeless
Hospitalization
Nursing Home
Single Room Occupancy (SRO)
Shelter/Mission
Personal Care Home
Therapeutic Group Home
Non-Mental Health Group Home
Foster Home
Living Independently with Others
Living Independently
Therapeutic Foster Care
Residential Treatment Facility
Living with Family

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First Health Services of Montana
Clinical Eligibility Assesment for MHSP Applicants

Name: Last _____ First: _____
SSN: _____

If individual is homeless or unemployed is it due to a mental illness: Yes • No •
Financial Support: SSI: Yes • No • SSDI: Yes • No •
Needs for daily assistance with ADLs: (describe needs and comment on ability to live independently)
List Signs/Symptoms: (Substantiate the Diagnosis)
Current Psychotropic Medications: (if none, has a referral been made for a medication evaluation?)

Name of Medication:	**Dose/Frequency**

"I certify that I am the person who performed face-to face clinical assessment and the above statements are true and current."

Provider Signature: _____ Title: _____

Printed Name: _____ Date: _____

Supervisor Signature:_____ Date: _____
(if applicable)

First Health Services of Montana Use Only:

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Reviewed By:_____ Date: _____
APPROVED: SED_____ SDMI _____ **DENIED**: SED_____ SDMI _____

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